



Send completed forms  
DPHHS CDEpi  
Program  
Fax: 800-616-7460

LHJ Case ID \_\_\_\_\_  
Reported to DPHHS: ☐ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Classification: ☐ Confirmed ☐ Probable  
☐ Suspect ☐ Not a case ☐ Unknown  
Method: (check all that apply)  
☐ Lab ☐ Clinical

☐ Outbreak-related

LHJ Cluster# \_\_\_\_\_

DPHHS Outbreak # \_\_\_\_\_

NEDSS

ID

MMWR  
(wwyy)

# Hepatitis C, chronic

County/

Tribal Jurisdiction

REPORT SOURCE ☐ Initial ☐ Update: date \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial report date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

Is case notified of diagnosis ☐ Yes ☐ No

☐ Don't know

Investigation  
start date:  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Data Source for Investigation

Source

Name \_\_\_\_\_ Phone \_\_\_\_\_

HCP

Name \_\_\_\_\_ Phone \_\_\_\_\_

## For HEPATITIS C ACUTE report on CDC VIRAL HEPATITIS CASE REPORT (draft version)

### CASE INFORMATION

Name (LAST, First, MI) \_\_\_\_\_

Address \_\_\_\_\_ ☐ Homeless

City/State/Zip \_\_\_\_\_

Phone(s)/Email \_\_\_\_\_

Alt Contact Name: \_\_\_\_\_ Phone \_\_\_\_\_

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other \_\_\_\_\_

Occupation/grade \_\_\_\_\_

Employer/worksites \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_

School/daycare name \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino  
☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian  
☐ Native HI/other PI ☐ Black/Afr Amer  
☐ White ☐ Other

### CLINICAL INFORMATION

Diagnosis date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Y = Yes DK = Don't know  
N = No NA = not applicable

Y N DK NA

☐ ☐ ☐ ☐ Was HCV chronic diagnosed in the past

Year of diagnosis: \_\_\_\_\_

☐ ☐ ☐ ☐ Was HCV chronic reported in MT. Year \_\_\_\_\_

☐ ☐ ☐ ☐ Is the person living? If no, date of death \_\_\_\_\_

☐ ☐ ☐ ☐ Is the person pregnant EDD: \_\_\_\_\_

Reason for HCV testing:

Y N DK NA

☐ ☐ ☐ ☐ Blood/Organ donor screening  
☐ ☐ ☐ ☐ Evaluation of elevated liver enzymes  
☐ ☐ ☐ ☐ Followup testing (prior viral hepatitis marker)  
☐ ☐ ☐ ☐ Prenatal screening  
☐ ☐ ☐ ☐ Screening: asymptomatic with risk factors  
☐ ☐ ☐ ☐ Screening: asymptomatic without risk factors  
☐ ☐ ☐ ☐ Symptoms of acute hepatitis  
☐ ☐ ☐ ☐ Other -(add information to notes)

Immunity to Hepatitis A (HAV) and Hepatitis B (HBV)

Y N DK NA

☐ ☐ ☐ ☐ Documented HAV illness Date: \_\_\_\_\_

☐ ☐ ☐ ☐ Documented HBV illness Date: \_\_\_\_\_

☐ ☐ ☐ ☐ Ever received vaccine against HBV and/or HAV

Number of valid doses of HBV vaccine \_\_\_\_\_

Number of valid doses of HAV vaccine \_\_\_\_\_

Treatment

Y N DK NA

☐ ☐ ☐ ☐ Does person currently have a HCP who monitors HCV

☐ ☐ ☐ ☐ Was HCV treated in past? Year treated \_\_\_\_\_

☐ ☐ ☐ ☐ Is person currently receiving HCV treatment

☐ ☐ ☐ ☐ Is person planning HCV treatment in next 12 mo

### Laboratory

Collection date \_\_\_\_/\_\_\_\_/\_\_\_\_

Laboratory \_\_\_\_\_

Specimen source \_\_\_\_\_

P N I O NT

☐ ☐ ☐ ☐ ☐ Repeat reactive anti-HCV screen (EIA)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ ☐ Anti-HCV screen (EIA) with signal to cut-off  
ratio (s/co r) >confirmatory reference value

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ ☐ HCV RIBA (recombinant immunoblot assay)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ ☐ HCV RNA quantitative

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Value: \_\_\_\_\_/mL ☐ I.U. ☐ RNA

☐ ☐ ☐ ☐ ☐ HCV RNA qualitative

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ ☐ ☐ ☐ HCV genotyping

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Results ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Unk ☐ Other \_\_\_\_\_

☐ ☐ ☐ ☐ ☐ Other test \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Liver Function Tests

☐ ☐ ☐ ☐ ☐ Alanine aminotransferase (SGPT or ALT)

exceeds high value of reference range Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Actual Value \_\_\_\_\_ Reference range high \_\_\_\_\_

☐ ☐ ☐ ☐ ☐ Aspartate aminotransferase (SGOT or AST)

exceeds high value of reference range Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Actual Value \_\_\_\_\_ Reference range high \_\_\_\_\_

**EXPOSURE INFORMATION**☐ Exposure information could not be obtained**Exposures**

Did/Was the case:

**Y N DK NA**

- ☐ ☐ ☐ ☐ Receive a blood transfusion prior to 1992  
☐ ☐ ☐ ☐ Receive an organ transplant prior to 1992  
☐ ☐ ☐ ☐ Receive clotting factor concentrates produced prior to 1987  
☐ ☐ ☐ ☐ Ever on long term hemodialysis  
☐ ☐ ☐ ☐ Ever injected drugs not prescribed by a doctor even only once or a few times  
☐ ☐ ☐ ☐ Ever incarcerated  
☐ ☐ ☐ ☐ Ever treated for a sexually transmitted disease  
☐ ☐ ☐ ☐ Ever a contact of a person who had hepatitis  
☐ ☐ ☐ ☐ Ever employed in a medical or dental field involving direct contact with human blood

\_\_\_\_\_ How many (approximate) sex partners has the case had over their lifetime

☐ No risk factors or exposures could be identified

PUBLIC HEALTH ISSUES		PUBLIC HEALTH ACTIONS
		<input type="checkbox"/> Recommendation for ongoing HCP follow up <input type="checkbox"/> Referral to HCP for follow up <input type="checkbox"/> Recommendation for HBV/HAV vaccine, if indicated <input type="checkbox"/> Referral for HBV/HAV vaccination <input type="checkbox"/> Education regarding transmission and prevention of transmission <input type="checkbox"/> Other, specify: _____
<b>NOTES</b>		
Investigator	Phone/email:	Investigation complete date ____/____/____
Local health jurisdiction		Record complete date ____/____/____